Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MedMe Services Corporation

Respondent Name
El Paso ISD

MFDR Tracking Number
M4-14-2671-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
April 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The requested additional payment for the rental and the fitting of the TENS unit is fair and reasonable. Both the TENS and NMES units are rented and purchased items. Both are listed in the DMEPDAC. The 2 items crosswalk with rental and purchase. Therefore we respectfully request additional payment for both the rental of and the fitting of the TENS unit."

Amount in Dispute: $283.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An additional allowance of $12.14 plus any applicable interest is being recommended for procedure code E0730RR. This amount plus the previous prior reimbursement amount of $36.765 equals a total recommendation of $48.90. This is the equivalent to 10% of the purchase price of $489.08 for a TENS unit. The 2014 HCPCS Level II code book indicates the description for procedure code A9901 is: DME delivery, set up, and/or dispensing service component of another HCPCS code. Chapter 20 of the Medicare Claims Processing Manual indicates delivery and service are an integral part of the supplier's costs of doing business. Medicare does not provide a reimbursement for code A901, therefore, no allowance is recommended."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2014	E0730 RR A9901	$283.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 96 – A Non-covered charge(s). "Tax, Freight, Shipping and Handling charges are not a reimburseable

benefit.

- 217B – Based on payer reasonable and customary fees
- W3 – No reimbursement recommended on reconsideration/appeal

Issues

1. Is there an established fee schedule amount for services in dispute?
2. Is the delivery and fitting separately payable?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202 states, in pertinent part "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Review of the submitted documentation finds HCPCS code E0730 – RR was submitted on claim line. Per DMEPOS Fee Schedule the service in dispute is classified as "Inexpensive Routinely Purchased." CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, Subchapter 30.5 "For these items of DME, contractors pay the fee schedule amounts on a monthly rental basis not to exceed a period of continuous use of 15 months." Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11–30-12, Effective: 06-08-12, Implementation: 01-07-13) "The purchase price is determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to the two months rental. "EXAMPLES: The fee schedule amounts for an item of DME are ordinarily as follows: $500 for purchase when the item is new. $375 for purchase when the item is used. $50 per month for renting the item." Therefore, the division finds the service in dispute (E0730) fee schedule amount is the PDAC purchase amount divided by 10 or ($391.22 ÷ 10 = $39.12). The service in dispute will be reviewed per applicable rules and fee guidelines.

2. The carrier denied the disputed service, A9901 as, 96A – "Non-covered charges." Per 28 Texas Administrative Code §134.202 states, in pertinent part "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." The Medicare Claims processing manual, Chapter 20, has specific details in regards to delivery of DME items can be found at www.cms.hhs.gov, and states, "60 - Payment for Delivery and Service Charges for Durable Medical Equipment (Rev. 1, 10-01-03) B3 – 5105 Delivery and service are an integral part of oxygen and durable medical equipment (DME) suppliers' costs of doing business. Such costs are ordinarily assumed to have been taken into account by suppliers (along with all other overhead expenses) in setting the prices they charge for covered items and services. As such, these costs have already been accounted for in the calculation of the fee schedules. Also, most beneficiaries reside in the normal area of business activity of one or more DME supplier(s) and have reasonable access to them. Therefore, DME carriers may not allow separate delivery and service charges for oxygen or DME except as specifically indicated in §§90 or in rare and unusual circumstances when the delivery is not typical of the particular supplier's operation." No documentation was presented to support an unusual circumstance prompted the requestor to submit delivery charges. The carrier's denial is supported.

3. 28 Texas Administrative Code §134.203 (c)(A) states in pertinent part, "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: … (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule; Therefore the total MAR is calculated as follows DMEPOS fee schedule $39.12 x 125% = $48.90. The carrier paid $48.90, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.